CARES Commission

PUBLIC COMMENT FORM
Public Hearing September, 29, 2003
VA Long Beach Healthcare System

Testimony of Sandra Lee

Pick the Topic(s) you wish to comment on! (you may pick one or more)		
Inpatient Care ☐ Medicine ☐ Surgery ☐ Psychiatry	**Outpatient Care** ☑ Primary Care ☐ Specialty Care ☐ Mental Health	**Non Clinical** ☐ Research ☐ Administration
Facility Issues ☑ Access to Primary Care ☐ Access to Hospital Care ☐ Travel time to Facility ☐ Facility Space ☐ Facility infrastructure ☐ Fire and Safety ☐ Patient Privacy	**Special Disability Programs** ☐ Spinal cord Injury ☐ Blind Rehab	**Other** ☑ Any other issues Quality of care

The VA CARES Commission welcomes your comments on the Draft National CARES Plan (DNCP) and how it relates to particular Markets. The Commission will not be able to reply individually to comments, however your comments will be taken into account during Commission deliberations.

Everyone is welcome to submit written comments for ten calendar days after each hearing on issues reviewed at the hearing. In addition, comments may be submitted on the DNCP until October 7, 2003.

Comments on the testimony or the DNCP may be submitted on the web at
www.carescommission.va.gov/Comments.asp

By U.S. Mail or other mail services marked "COMMENTS" addressed to:

Richard E. Larson, Executive Director
CARES Commission, (00CARES)
810 Vermont Avenue, NW
Washington, DC 20480,

or by facsimile at (202) 501-2196.

You may also provide your written comments on the back of this form.

PUBLIC COMMENT FORM
Public Hearing September, 29, 2003
VA Long Beach Healthcare System

There are many problems with contract CBOC's.

1. Some of them do not meet the quality assurance guidelines in clinical reminders. Administrators are aware, but no action is being taken.

2 Low patient satisfaction. A lot of patients simply will not go to these clinics, instead they continue to go to VA staff clinics. These statistics will not show up in patient satisfaction surveys because the dissatisfied patients are not registered as CBOC clinic patients.

3 Contract CBOC retain only healthy patients who do not require a lot of care. HMO model of corporation encourage these clinics to abandon more complicated patients.

4 Access is another issue. Some of these clinics require pts to make appts even for lab draws (more waiting) Hence, these pts end up at VA staffed clinics for additional appts + lab draws even though VA staffed clinics are not given resources to provide these care

5 At East LA clinic, pts are ~~not~~ seen only every 6 months. Which in a lot of cases are inappropriate.

6. VA should not close VA staffed CBOC and convert them to contract CBOC whose staff are less experienced and less committed to veterans.

BETTY R. TERRY, RN

September 19, 2003

My name is Betty R. Terry
I am a Registered Nurse. I retired in April of 2003 after 38 years and 10 months of employment at Greater Los Angeles Healthcare System. During my employment, I worked in every nursing area of the hospital, spending the majority of my time in critical care and the emergency room.
I am the president of AFGE Professional local # 3943. My local represent over 600 professional employees through out GLA...

Greater Los Angeles Healthcare System provides a broad range of inpatient and outpatient health care services to our veterans. Such as Medical, Surgical, Mental Health, Geriatric advance rehabilitation services as well as a research unit to 281,526 patients at the present. It is estimated that by year 2022 we will be providing care to approximately 233,489 patients. A 24 % decline in the Veterans population and a 17 % decline in Veterans enrollment.

I am concerned that the VA CARES recommendation does not take into account the fact that the average age of our veterans today is about 58 years old. In addition, that the population of elderly veterans will grow by 500,000 over the next seven years, and the number of very elderly veterans (age 85 plus) will triple to over 1.3 million for at least the next 20 years.

I am concerned that the young men and women who risked their lives to save our country will not be able to received long-term care at VA Facilities in the future, rather their care may be privatized and they will not have the benefit of specialized veteran's only facilities. Providing veterans' care at veteran's facilities was a Solemn Promise that CARES tries to break.

I am also concerned that our Veterans are getting sicker and even dying earlier in contract facilities, because the staff at these facilities likes the knowledge and skills to give the quality of care our veterans are accustom too.
Contract Facility are notorious for under staffing and failing to provide any continuity of care, since the turn over is very high and morale is very low. Profit is a high priority and patient care becomes a low priority at these types of facilities. Our Veterans deserve a higher standard of care than this.

I understand that building new clinical additions, new ambulatory care centers and increasing CBOCs' will meet the needs of our veterans population in the next 5 years , but this alone will not be sufficient to handle the long term care needs of our elderly population in year 2022 .

In my conclusion.
I believe CARES is not about moving facilities and capacity to locations where the veterans are. It is about closing down facilities and reducing capacity so that veterans care can be privatized and veterans will no longer have access to specialized care in Veterans'-only facilities
Privatization will cost more and veterans will get less, lower quality of care, less continuity, less specialized care, less commitment and less recognition.

I am concerned that thousands of our veterans will lose their jobs. Taxpayers will lose and federal employees who have devoted their lives caring and promoting the interests of our veterans will lose.
Commission I asked you in your recommendation to make sure that there will be enough long-term care beds to meet the needs of our elderly Veterans in year 2022. So they will not be forced into the already overloaded Medicaid System to get the care they deserve.

Thank you:

Betty R Terry

VA LONG BEACH
HEALTHCARE SYSTEM
A Division of VA Desert Pacific Healthcare Network

September 15, 2003

Everett Alvarez, Jr.
Chairman
CARES Commission
Department of Veterans Affairs

Dear Mr. Alvarez and members of the CARES Commission,

Thank you, for the opportunity and invitation to appear before and provide input to the CARES Commission. I would like to offer my written statement to you at this time. If you feel that it merits presentation at the hearing on September 29, 2003 at VA Long Beach Healthcare System, I would be honored to attend.

As a staff member in the Department of Veterans Affairs (DVA) for over 25 years and as President of our Long Beach Chapter of the Nurses Organization of Veterans Affairs (NOVA), I recognize that DVA must continue to progress in this ever-changing healthcare environment. Although our VA philosophy and mission of providing quality healthcare for veterans is never outdated, the methodology and environment in which we choose to provide care has certainly needed an upgrade for decades. We have maintained facilities in beautiful locales, such as Long Beach, but have failed to assure that the buildings, structures and locations remained cost efficient and customer appealing. California facilities are certainly unique in their need to maintain safety by providing structures that are earthquake resistant. VISN 22 has been particularly vulnerable with the reduction of structures at the Sepulveda site but has assured that inpatient services remained intact throughout the rest of the facilities. Existing buildings must be made earthquake safe to not only meet the California requirements of 2008 but also to meet the continuing workload demands for inpatient services at our local sites. The VA Long Beach Healthcare System recognized this early on and has begun to move inpatient and outpatient services into Building 126 its most structurally safe building. Building 126 can only accommodate about 40% of our services. so other structures either need to have their seismic upgrading completed, or be removed and replaced. Our location provides for easy accessibility by multiple freeways and roadways and our available land affords us the opportunity to remove outdated and unsafe structures and replace them with state of the art buildings conducive to patient services.

The planned 24-bed Blind Rehabilitation Center at the Long Beach site is highly desired. Access to the existing programs is difficult for patients and families who are unable or unwilling to travel to out-of-state locations or away from their zone of comfort. We are also able to provide a small town environment that facilitates training and education due to our close access to a major downtown hub, education resources available at California State University, Long Beach, immediately adjacent to this facility, and other sites which will be used to facilitate every-day independence.

As a major provider in the care for Spinal Cord Injury (SCI) patients, we recognize that the community at-large has very limited capability to assist SCI patients in their transition to other levels of care. In addition, as veterans age, their care providers, often their own family members, also age and are no longer able to provide care, the long-term care needs of this highly specialized patient population becomes more difficult to manage. The proposed conversion of acute care beds into long-term care beds is an effective utilization of existing vacant beds.

It would be remiss not to address a major concern in the implementation of the CARES Plan: the ability of the VA to continue to be the primary, even the premier, healthcare provider without assuring that our staffing resources are in line to meet our patient care needs. VA has taken the appropriate direction in reducing the inpatient beds and redirecting resources and personnel into the Community Based Outpatient Clinics. It has also designed, and is designing, programs which focus on the continuum of care such as the Geriatric Evaluation Management Program and the Care Coordination/Telehome Care initiative. DVA developed and instituted the Nursing Commission to review the current and projected nursing staff needs. At local levels it is evident that each facility is attempting to maximize it affiliations with nursing programs by continuing to provide an educational environment conducive to developing future nurses. The VA's opportunities for scholarships and tuition reimbursement are recognized and valued by those who can afford the time and opportunity to pursue higher education. However, many staff have difficulty juggling a full-time work schedule with family demands, and the Healthcare Systems find it difficult to adjust schedules to permit such class attendance without supplementing staffing vacancies with overtime or contact staff. We often fail to attract "new blood" since we cannot offer the entry salaries available in the community. Retention of nursing staff has become increasingly difficult when it becomes evident that salaries and promotion opportunities have become the driving force for the younger and more mobile staff. This not only applies to the licensed Registered Nurse (RN) staff but to all staff that contribute to patient care. The DVA desires to maintain a standard of nursing excellence as evidence in its new RN and Licensed Vocational Nurse (LVN) qualifications standards. We also need to be able to provide salaries and incentives that are competitive, flexible and driven by local market forces in order to assure we can recruit and retain nursing staff. We need to stop "robbing Peter, to pay Paul" by looking at VISN salaries and those specialty areas, such as critical care, where competition is steep. The following recommendations are provided:

- Review current salaries designated for nursing positions across VISN 22 to assure fairness and minimize competition among the VISN Healthcare

Systems. This issue is not unique to this VISN and must be addressed throughout the DVA.

- It is recognized that the RN Nursing Qualification Standards have changed the minimum entry level for RN recruitment and advancement. Many RN's currently in the system will not be able to meet these requirements. Encouraging stations to provide additional steps in pay grades beyond those currently established would provide an incentive for retention.
- It is recognized that the LVN Nursing Qualifications Standards have added an additional grade, LVN 7. Promotion to this new grade in most assignments and locations is proving to be quite limiting. Encouraging stations to provide additional steps in pay grades beyond those currently established would provide an incentive for retention.
- An aging workforce is not unique to the nursing profession. DVA recognizes and values those current programs to educate, retain and promote staff into alternative positions. However, this cannot be done in an effective manner while an individual remains assigned to their current position while trying to find the time, and energy, to attend classes and programs which will lead them to a new assignment.
- We must recognize and correct the imbalance that takes place when we have nurses assigned to non-clinical positions and are attached to the Healthcare Systems nursing FTEE. Nursing education encourages the development of an individual with a unique balance of critical thinking, problem solving and people-skills. They often result in an employee who can apply their skills away from the bedside, yet make significant contribution to the overall organization. The nursing FTEE should apply to those providing direct patient care and not necessarily reflective of all nurses in the organization.
- Finally, recruitment of competent and dedicated nursing staff, at all levels, remains an ongoing problem. It is difficult to pinpoint one particular area, whether it is the timeliness of initiating the recruitment announcement, or completion of the entry requirements for hiring, or release of the individual from their current assignment, we remain unable to fill a position until the staff member has been gone for a period of time. Replacement staff often comes 3-6 months after the person has left. In programs where a single nurse is responsible for the coordination of the program, it becomes difficult to maintain the quality and integrity of the program until the replacement staff arrives. We must be permitted to hire, and orient or cross-train replacement staff to assure the continuity of patient care.

Thank you for the opportunity to present my views. I believe they also reaffirm many of the same viewpoints and thoughts of my colleagues.

Donna M. Soroczak, MSN, RN
Associate Chief/Nurse Leader, Geriatric, Rehabilitation Medicine and Extended Care
Health Care Group